Weissman

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE
03-001	Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECEIVED
APR 2 2003

4. PROPOSED EFFECTIVE DATE
January 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2002 $0 b. FFY 2003 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Appendix C1 to Supplement 2 Page 20	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Appendix C1 to Supplement 2 Page 20

Washington (03-001)
approved: 05/22/03
effective: 01/01/03

10. SUBJECT OF AMENDMENT:

Private Duty Nursing

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: DENNIS BRADDOCK	Department of Social and Health Services Medical Assistance Administration 925 Plum St SE MS: 45533 Olympia, WA 98504-5533
14. TITLE: Secretary	
15. DATE SUBMITTED: 3-31-03	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR - 2 2003	18. DATE APPROVED: MAY 2 2 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: /S/
21. TYPED NAME: Karen S. O'Connor	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

RETURNED 3/31 (Date) Olympia (Loc.)

FORM HCFA-179 (07-92)

State: WASHINGTON

DEFINITION OF SERVICES (con't)

2. _____ Private duty nursing services are not limited to services provided in the individual's home or place of residence.

Check one:

A. X Services may also be provided in the following locations (Specify): Only in the individual's home or in a licensed adult family home that has a contract (in accordance with state rules for these homes) with the state

B. _____ The State will not place limits on the site of private duty nursing services.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. X The State will impose the following limitations on the provision of this service (specify):
a. The client must require at least 4 continuous hours of skilled nursing care on a daily basis; and
b. Must require at least one of the following on a daily basis:
(1) A mechanical ventilator;
(2) Tracheostomy tube care/suctioning;
(3) Intravenous/parenteral administration of medications; or
(4) Intravenous administration of nutritional substances.

r. _____ Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _____ Physician services.

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

_____